IDOA Testimony on Nursing Home Safety

November 5, 2009

Chairman and members of the Senate Public Health and Senate Human Services Committee, thank you for the opportunity to address the issues of safety in nursing homes. My name is Charles Johnson and I am the Director of the Illinois Department on Aging.

The Department on Aging is committed to the safety and protection of all persons over the age of 60, regardless of whether they reside in the community or in a long term care facility. I would like to thank the members for convening this hearing, as well as Governor Quinn for convening the Nursing Home Safety Task Force to deal with this complex issue. To resolve this issue will require consolidated efforts by government and the nursing home industry to implement needed reforms.

quality of life and care of residents. This program acts solely on behalf of the thousands of individuals who live in long term care facilities. Ombudsmen investigate and resolve resident complaints and provide information about regulatory standards; medical coverage; and resident rights, including transfer or discharge to residents and their families. They also monitor regulations and government agency action that could impact residents and then take on an advocacy role to communicate resident interests to policy makers.

Let me give you a few more details about the Choices for Care Program. This program involves a universal pre-screening process for all nursing and supportive living facility placements. Universal pre-screening is defined as "the assessment of the need for long term care placement of all individuals age sixty (60) or over, regardless of payment source, prior to placement in a nursing facility." Its purpose is to (1) educate individuals at risk of nursing facility

nursing facility. Obviously, hospital patients who may still require extra care are to be identified as priority assignments.

Once a referral is made, required timeframes come into play to ensure prompt action in completing the pre-screening process. If the individual is at imminent risk of being placed in a nursing facility within seventy-two (72) hours, a Community Care Program Screening Information form must be completed within two (2) calendar days of the referral. The pre-screening process will determine if the individual is truly in need of nursing facility placement, or community-based services.

As part of their contractual relationship with the Department, Care Coordination Units are advised that the required timeframes are the maximum limits due to the urgent need for services, whether for a nursing facility or for home and community-based options.

- Individuals who resided in a nursing facility for a period of at least sixty (60) calendar days who are returning to a nursing facility after an absence of not more than sixty (60) calendar days.
- Individuals discharged from a hospital to a hospital licensed care facility (licensed under the Hospital Licensing Act or Alternative Health Care Delivery Act) for a period of not to exceed twenty-one (21) calendar days.
- Individuals who resided in a nursing facility prior to July 1, 1996.

The exceptions apply in situations where the pre-screening typically will not lead to more appropriate options than a previously planned or medically recommended institutional placement.

Upon the completion of a Community Care Program Screening Information form, the Care Coordination Unit will assist an applicant or current client by arranging one of the following choices for care: (1) Nursing Facility Placement, (2) Community-Based Services, or (3) Private Pay Home and Community-Based Services.

If the client chooses Community-Based services and is new to the program the case manager may work on setting up Interim Services. Interim services are provided based on presumptive eligibility until a final determination is reached regarding services under the Community Care Program is appropriate. Its use reflects the difficult pressures faced by case mangers in coordinating services for at risk individuals in a limited period of time.

Similarly work could be required for a current client under the Community Care Program who periodically requires a Temporary Service Increase to enable them to continue

As our population continues to age, the need for the services provided by the Department continues to grow. According to our data for FY 09, there were 93,971 pre-screens performed at a cost of $ 8,406,651. In conclusion, I think you will agree with me that our mission and the work that we do with the other entities in the Aging Network is vitally important to all of us.

Illinois applied for and was approved for a Money Follows the Person (MFP) demonstration award from the federal Centers for Medicare and Medicaid Services (CMS) in May 2007. MFP supports states creating systems and services to transition long-stay Medicaid-eligible persons residing in institutional settings to appropriate home and community-based settings (HCBS) in order to rebalance the states' overall long-term care (LTC) system.

The Illinois Department on Aging has contracted with Case Coordination Units and Case Management Units under the Community Care Program (CCP) for care coordinators to serve as

Recommendations

The most basic recommendation I can offer to improve safety in nursing homes is to continue to work at reducing the number of residents in facilities. This can be accomplished by supporting in-home and community-based options for care, and programs like Money Follows the Person. Nursing homes should only be reserved for those individuals truly in need of 24-hour care and not used because a lack of affordable housing, community services, and other less restrictive options.

In-home and community-based options are important to the population that we serve. The Department on Aging needs the resources and stable funding that are necessary to allow us to meet increasing service demands due to our growing senior population. Let's maintain our initial investments in programs such as Home Delivered Meals and Transportation Services, but also keep forging forward by supporting expansion of the Community Care Program - by enhancing

Illinois Department of Veterans Affairs testimony to the joint hearing of the Senate Human Services and Public Health Committees

By

Cathy Page
Director of Nursing
Illinois Veterans Home at Quincy

Mr. and Madam Chair, members of the committees, thank you for the opportunity to speak to you today. My name is Cathy Page, and I am the Director of Nursing at the Illinois Veterans Home in Quincy. The Illinois Department of Veterans Affairs oversees four State Veterans Homes located at Anna, Quincy, LaSalle and Manteno. The four homes have 1,008 skilled nursing care beds, 133 dementia care beds and 144 domiciliary beds. Only veterans are eligible for admission to the homes at Anna, LaSalle and Manteno and both veterans and non-veteran spouses are eligible for admission to the Quincy home. The average age of our residents is over 70 years old. The Illinois Veterans Homes are regulated by both the Illinois Department of Public Health and the Federal Veterans Administration.

Although we have a unique population and by definition of who we serve haven't experienced some of the same issues as other Illinois nursing homes, we do provide nursing home care and have many residents with mental illness. Residents with mental illness are co-mingled with the general nursing home population. Before any applicant is approved for admission, a pre-admission screening process occurs. This pre-screening allows us to assess that we are able to provide the services that the veteran needs and to ensure that the safety of all existing residents can be maintained if the applicant is admitted.

A Health Questionnaire is completed by a physician and must reveal current diagnoses as well as any psychiatric history and behavioral problems. If a psychiatric history exists, psychiatric notes are required and thoroughly reviewed by a committee consisting of the Medical Director, Administrator, Director of Nursing, Social Worker and the Adjutant. This committee then determines if the applicant's needs can be met with the available resources at the home. Applicants known to be dangerous or who are psychiatrically unstable, are denied admission. In addition, in order for an applicant with a mental illness to qualify for admission, the applicant must also have another disease process that necessitates nursing home care. He or she must show a need for assistance in performing some aspect of activities of daily living such as bathing, dressing, feeding, or medication administration. The need for physical assistance must be based on his or her physical condition rather than mental condition. All applicants must undergo a State Police background check and screening of the Sex Offender Data Base prior to admission. No applicant is admitted to a state veterans home until the results of these background checks are received and the results reviewed.

The homes all have social workers on staff and do provide limited mental health services to our veterans. In addition, the largest home at Quincy (over 450 residents) has a contractual agreement with a geriatric psychiatrist. The psychiatrist makes rounds at the facility weekly and is available for consultation with the medical staff at the home as needed. The Quincy home also recently hired a full-

Testimony for the Public Health and Human Services Joint Hearing on Nursing Homes Serving Person with Mental Illness

November 5, 2009

Patricia Werner
Staff Attorney, Legal Advocacy Service

The Legal Advocacy Service of the Illinois Guardianship and Advocacy Commission represents respondents in civil commitment and treatment cases. As you probably know, before a court commits a person to a locked psychiatric hospital, it must be provided with a report on the availability of less restrictive alternatives; it must consider the report in determining disposition and it must order the least restrictive alternative. (405 ILCS 5/3-810, 811, 812 (2008)).

In theory, the court has several alternatives to hospitalization from which to choose: partial hospitalization programs, community mental health centers, community living facilities, or it can place the person in the care and custody of a relative. But, as you have been hearing, these alternative placements are not readily available in Illinois. As a result, courts often commit those found subject to involuntary admission to a psychiatric hospital, negating the promise of treatment in the least restrictive setting. Although I am focusing on recipients who go through the civil commitment system, the same issues arise--lack of appropriate community based living arrangements-- for persons not alleged to be subject to involuntary admission. In fact, for those people, the issues may be exacerbated because there is no court oversight and no limit on the time recipients can be detained in institutional settings.

At least a cursory understanding of deinstitutionalization is important in understanding nursing homes serving the mentally ill. Until the 1960s, persons with mental illness were almost always held in large, usually state-operated psychiatric facilities. The abhorrent conditions in these institutions have been well documented. Increased awareness of the conditions of the facilities and the "treatments" provided in them prompted calls for social reform. Proponents of change argued for community-based alternatives to the large and impersonal state facilities.

Instead, what developed were large and impersonal *private* facilities. They range in size from about 150 beds to more than 400 beds. It is axiomatic that individualized attention is less likely in a large institution than in a smaller, more personal setting. Unfortunately, the staff persons in these facilities often lack adequate training and experience in treating people with mental illness. Seldom do they see their role as preparing residents to move forward to more independent living. Because these facilities provide little in the way of

meaningful treatment, they foster a dependence that can actually foreclose future independence.

Not only do staff persons at these facilities fail to foster independence, they are often unmindful of resident rights. Rights of recipients of mental health services are set out at 405 ILCS 5/2-100 *et seq*. (2008). The Illinois Appellate court, in Muellner v. Blessing Hospital, made clear that the Mental Health Code applies to nursing homes providing mental health treatment. This ruling should be codified. The Department should enact regulations requiring compliance and employ staff with expertise in mental health treatment to ensure that resident rights are safeguarded.

This suggestion is only a first step. As mentioned earlier, there must be other community-based alternatives. The promise of treatment in the least restrictive setting is meaningless if there are no realistic alternatives to institutional care. Large nursing homes fail to provide the meaningful community-based alternative treatment that advocates sought more than 40 years ago. A continuum of services would better and more efficiently meet the needs of persons with mental illness in Illinois.

STATE OF ILLINOIS
Pat Quinn
· Governor

GUARDIANSHIP & ADVOCACY COMMISSION
Dr. Mary L. Milano, Director

HUMAN RIGHTS AUTHORITY
LEGAL ADVOCACY SERVICE
OFFICE OF STATE GUARDIAN

Testimony for the Public Health and Human Services Joint Hearing on Nursing Homes Serving Persons with Mental Illness

November 5, 2009

Dr. Mary L Milano, Executive Director, GAC
Patricia Werner, Staff Attorney, Legal Advocacy Service of GAC

I. General Comments.

Good morning.

I would like to begin by thanking the members of the Task Force and the many others in the public and voluntary sectors whose concerns and efforts they represent for the opportunity to testify today on behalf of our agency, its professional staff and more importantly the thousands of Illinois residents whom we represent, as guardian, as legal advocate, as a set of eyes of the larger communities across the State who are entrusted with the care of those who are disabled.

For those of you who are unfamiliar with our agency, we are an institution fairly unique to the State of Illinois, which serves as the guardian of last resort for the disabled. Last resort means that the 5400 Illinois residents whom we represent as Guardian are too poor for the county systems, too alone for the private sector, and often too marginalized for other voluntary entities. We average one case worker to 120 wards located in every county in the state. We also provide legal advocacy for respondents in civil commitment and treatment cases, as well as other mental health and special needs litigation, serving clients, principally with MI diagnoses in approximately 8500 cases in the last year. Finally we have, through our Human Rights Authority investigated in the last full year 321 cases of rights violations for persons with disabilities, benefitting some 22,000 citizens of the State, principally through supporting nine regional volunteer panels across the state.

I mention the above because our involvement, particularly in the areas of mental health and development, comes from several directions. And those directions result from the representation of classes of individuals whose interests are often set against each other in the public view and the larger "system." The majority of our wards have developmental disabilities. But close to 2000 of them have diagnoses in whole or in part of mental illness. Our clients can be what we have come to think of as those who are "victims" within care settings. They can also be what we sometimes characterize too easily as "perpetrators." They can have histories that include criminalized behaviors, violence, and even sexual predation. They can be those who are simply "unable" for a variety of reasons to care for themselves. They can be a danger to themselves and others. They can be amenable to productive life in the larger society with adequate treatment. They can simply be very poor and on the edge too long. They can suffer from nothing other than being old and alone, or young and confused.

What is a common thread to all of our clients' stories and the real reason we are here today, is that they are the ones for whom you, as those who represent the people of this State in positions of elected and appointed authority, are directly responsible, through us. They are those who we are mandated to protect precisely because we - and through us you - are here and no one else is.

And that relationship creates a bond and a responsibility which exceeds even that very sacred trust reposed in all of us by the members of the communities of the state at large.

I will not take your time to point out the problems our constituencies experience. You have heard that already. I do want to look briefly at several areas of solution, and these are common to all, and spring from the need for services and settings appropriate to the differentiated needs of those served and placed.

The first is that we support an approach to the treatment of the mentally ill used successfully in the DD service delivery system, creating specialized facility licenses for the elderly, the elderly who are mentally ill, younger persons with MI diagnoses, younger persons with physical handicaps, whether the result of chronic conditions or trauma, and felons and persons with records of sexual offenses who are also disabled. We believe that real treatment options must be included in each of these types of facilities.

The second is that we support the creation of community based and supervised CILA's serving these populations, with concomitant reduction of IMD beds, thus adding options with lower cost, and proven higher effectiveness in place of high cost, institutionalized care.

The third is that we support requiring every facility that receives federal and state tax dollars to set aside a number of beds for "charity or pro bono" cases (including so called John Doe cases and those of undocumented immigrants) who are ineligible for services anywhere in the system.

Fourth, we support increased dollars for advocacy, as will be explained by my colleague.

The fourth is that we advocate aggressively for the exploration of a low cost model of oversight and intervention which follows the lines of our own, statutorily mandated Human Rights Authority, which investigates complaints of abuse and deprivation of rights by providers of services through citizen staffed panels, drawn from those in the community with expertise, or commitment or both, who can and do, with minimal cost and professional staff support, manage to achieve an over 95% rate of consensual, negotiated policy and procedural changes in facilities throughout the state, affecting both individuals and the systems in which they find themselves. This system is not only effective and low in cost, but serves as a bottom up (rather than top down) model of community involvement and responsibility for those who are members of our communities, enabling neighbors to serves neighbors, and those at the edges to achieve a voice of advocacy and concern typically had by those at the center. We believe that systems like this could be put in place to bear parts of the increased burdens of supervision and engagement which we believe these hearings will in the end require.

To conclude our testimony today, I would like to focus on a specialized area of our experience, advocacy for those facing civil commitments, with additional comments offered by one of our attorneys, Patricia Werner.

II. Perspective of Legal Advocacy Service

The Legal Advocacy Service of the Illinois Guardianship and Advocacy Commission represents respondents in civil commitment and treatment cases. As you probably know, before a court commits a person to a locked psychiatric hospital, it must be provided with a report on the availability of less restrictive alternatives; it must consider the report in determining disposition and it must order the least restrictive alternative. (405 ILCS 5/3-810, 811, 812 (2008)).

In theory, the court has several alternatives to hospitalization from which to choose: partial hospitalization programs, community mental health centers, community living facilities, or it can place the person in the care and custody of a relative. But, as you have been hearing, these alternative placements are not readily available in Illinois. As a result, courts often commit those found subject to involuntary admission to a psychiatric hospital, negating the promise of treatment in the least restrictive setting. Although I am focusing on recipients who go through the civil commitment system, the same issues arise--lack of appropriate community based living arrangements-- for persons not alleged to be subject to involuntary admission. In fact, for those people, the issues may be exacerbated because there is no court oversight and no limit on the time recipients can be detained in institutional settings.

At least a cursory understanding of deinstitutionalization is important in understanding nursing homes serving the mentally ill. Until the 1960s, persons with mental illness were almost always held in large, usually state-operated psychiatric facilities. The abhorrent conditions in these institutions have been well documented. Increased awareness of the conditions of the facilities and the "treatments" provided in them prompted calls for social reform. Proponents of change argued for community-based alternatives to the large and impersonal state facilities.
Instead, what developed were large and impersonal *private* facilities. They range in size from about 150 beds to more than 400 beds. It is axiomatic that individualized attention is less likely in a large institution than in a smaller, more personal setting. Unfortunately, the staff persons in these facilities often lack adequate training and experience in treating people with mental illness. Seldom do they see their role as preparing residents to move forward to more independent living and instead, foster dependence.

The failure to move toward independence is part of a bigger issue related to resident rights. Rights of recipients of mental health services are set out at 405 ILCS 5/2-100 *et seq.* (2008). The Illinois Appellate court, in Muellner v. Blessing Hospital, made clear that the Mental Health Code applies to nursing homes providing mental health treatment. This ruling should be codified. The Department should enact regulations requiring compliance and employ staff with expertise in mental health treatment to ensure that resident rights are safeguarded.

This suggestion is only a first step. As mentioned earlier, there must be other community-based alternatives. The promise of treatment in the least restrictive setting is meaningless if there are no realistic alternatives to institutional care. Several models currently exist: supportive living

arrangements, assertive community treatment, supported employment and outpatient clinical services. But the demand for these services is far greater than their availability. And it's not surprising. With an emphasis on treating recipients as consumers who have a stake in their recovery, community-based programs work with recipients to improve their lives through maximizing independence and preserving dignity.

The nursing home model fails to provide the meaningful community-based alternative treatment that advocates sought more than 40 years ago. It is expensive. It may violate federal law. And it doesn't serve the people of this state. We should significantly reduce the number of IMD beds. We must ensure that people and sufficient funding are moved to community based programs. An array of community based individualized services would better and more efficiently meet the needs of persons with mental illness in Illinois.

Respectfully submitted,

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